Visit note documentation

To capture the full disease burden of a patient at the time of the encounter, follow the documentation guidelines below, as applicable

Members with chronic medical conditions require additional services beyond preventive care. Accurate documentation is crucial to obtain appropriate reimbursement for services rendered. This ensures our members can continue accessing the care that they need.

Components of a visit note

CC = Chief complaint

Do document a concise statement that describes the:

- Symptom
- Problem
- Condition
- Diagnosis
- Physician follow-up
- Reason for the patient encounter

HPI = History of present illness

Do document a chronological description of the patient's present illness. This may include one or all the following depending on complexity:

- Context
- Duration
- Location
- Modifying factors
- Quality
- Severity
- Timing
- Associated signs and symptoms

PE = Physical exam

- The visual and tactile exam of the body that may address all systems.

PFSH = Past, family and/or social history
Do document:

- Past experiences with illnesses
- Operations
- Injuries
- Treatments
- Patients' family medical history

Plan = Orders
Do document:

- Medications with associated condition
- Diagnostics
- Patient education
- Durable medical equipment (DME's)

ROS = Review of systems
Do document:

- The signs and symptoms the patient may be experiencing per body system.

Assessment = Problems addressed during the encounter

Reference:

1. Crc, P. S. B. C. C. C. (2020). Risk Adjustment Documentation & Coding, 2nd Edition. In Common Administrative Errors and Processes. (2nd ed., pp. 51). American Medical Association Press.